STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000939	A. BUILDING _____ B. WING _____	05/19/2016

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FLANAGAN REHABILITATION & HEALTHCARE	201 EAST FALCON HIGHWAY FLANAGAN, IL 61740

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 330.1710 f) 330.1710 f) Resident Record Requirements An ongoing resident record including progression toward and regression from established resident goals shall be maintained. This requirement is not met as evidenced by: Based on observation, record review and interview the facility failed to have documentation in the resident record that included progression towards or regression from established resident goals. This has the potential to affect all 11 residents (R22, R101-103, 105-111) residing in the Shelter Care. The findings include: 1. On 5/16/16 at 9:35 am the Shelter Care section of the facility was toured with Certified Nurse Aide (CNA) E7 and the residents were interviewed. On 5/16/16 at 9:40 pm R102 was in the bedroom ambulating with a walker. R102 was wearing an oxygen cannula with a long tubing that was attached to an oxygen concentrator. There was also a small tank of oxygen with a stand. R102 stated that she utilizes oxygen at all times. R102's progress notes showed an admission date of 4/3/16. The May 2016 Physician Order Sheet (POS) list diagnoses that includes Chronic Obstructive Pulmonary Disease, Arthritis, Depression, Anxiety, Asthma, Hypertension, Osteoporosis, Compressed Vertebra, and Gastroesophageal Reflux Disease. Progress Notes dated 4/29/16 documented that staff smelled cigarette smoke in the hallway	S9999	Attachment A Statement of Licensure Violations	

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leading to R102's room and R102 was educated by Director of Nurses E2 that it was a non smoking facility and that smoking with oxygen can cause an explosion. The notes stated the resident handed over the cigarettes and lighter and agreed to try a nicotine patch.

There was no care plan or established resident goals identified in R102's record.

2. R101 has resided in the facility since 8/4/14. R101's May 2016 POS identifies diagnosis that includes; Atrial fibrillation, Depression, Vertigo, Dementia, and Basel Cell Cancer of left eyelid.

R101 was seated in a recliner in the bedroom on 5/16/16 at 9:45 am. R101 stated she had a terrible headache and experiences Vertigo and pain if she moves her head so R101 was going to stay in the room in her recliner chair for breakfast. R101 stated this is a chronic condition that has been occurring since a car accident in 2005 and worsened since eye surgery in 2015.

There was no care plan or established resident goals in R101's medical record.

3. R103's May 2016 POS lists diagnoses that includes; Low back pain, subluxation of lumbar vertebra, Chronic Kidney Disease, Depression, Anxiety, Acute Coronary Syndrome and Nicotine dependence.

On 5/16/18 at 9:50 am R103 was lying in bed. R103 stated she was ill with a sore throat and bad cough.
R103's May 2016 POS documents an admission date of 10/14/15.

R103's Progress notes dated 4/6/16 stated

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S9999	Continued From page 2 ...smoke smell in resident room..Administrator asked to have R103's smoking materials. R19's Situational Background Assessment Report (SBAR) dated 4/18/16 stated that R103 had requested a cigarette and a lighter and signed self out of the facility at 3:30 pm. R103 was later observed on the ground behind the garage in a cornfield. The resident told staff " I lost my footing, I was off property so I could smoke and this is off property." R103's Progress notes dated 4/20/16 stated that the resident had told daughter that (R103) would kill self. The notes stated that 15 minute checks were initiated and resident was moved to the certified part of the nursing home. R103 returned back to the shelter care after a 23 hour observation period. There was no care plan or established resident goals in R103's medical record. On 5/17/16 at 2:30 pm E4 Licensed Practical Nurse (LPN) stated "We don't have care plans for the shelter care residents because they are community independent." Administrator E1 stated on 5/18/16 at 5:00 pm that they do not have any written policies requiring care plans or establishing goals for Shelter Care residents. Minimum Data Set (MDS)/Care Plan Coordinator E3 stated on 5/18/16 at 12:10 pm that residents in the Shelter Care "are considered the community. We don't do care plans.." E3 stated the Administrator has the policy for the Shelter Care and it doesn't address care plans.	S9999		

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S9999	Continued From page 3 The facility Resident Room and Bed Roster dated 5/16/16 documents 11 residents (R101-103, R22 and R105-111) reside in the Shelter Care. (B) 330.4210f)g)o) 330.4210f)g)o) The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. (Section 2-103 of the Act) The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints. (Section 2-103 of the Act) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. These requirements are not met as evidenced by: Based on record review and interview, the facility failed to prevent misappropriation of controlled medication for one resident on the supplemental sample (R104). The facility also failed to report to the state survey and licensing agencies the allegation and substantiation of drug diversion. Findings include: The facility's Abuse Prevention Program dated	S9999		

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11/11/11 defines Misappropriation of resident property as "deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. . . .Initial Reporting of Allegations. The facility must ensure that all alleged violations involving. . . .misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. . . .the report must be made not later than 24 hours after forming the suspicion. . .A written report shall be sent to the Department of Public Health. . . Five-day Final Investigation Report. Within five working days after the report of the occurrence a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. . . .Informing Law Enforcement Authorities. If there is clear evidence of abuse by an employee, the Department of Public Health will notify. . . .the Department of Financial and Professional Regulation (IDFPR). . ."

On 5/18/16 at 8:45am, E2 (Director of Nursing) stated that in October of 2015 they had a situation of E19 (Licensed Practical Nurse) diverting Hydrocodone (narcotic analgesic. E2 also provided the summary of the investigation of the drug diversion. According to E2 and the investigation report, E2 became aware of a possible issue of Hydrocodone being signed out more frequently by E19 for residents who don't normally receive frequent pain medication. E2 informed E21 (Corporate Nurse) who called the Illinois State Police (ISP).

E2 stated they performed Urine Drug Screens on

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10/13/16, the day following when E19 worked. On 10/13/16, E2 identified residents who had Hydrocodone signed out by E19 on 10/11 and 10/12/16, and submitted Urine tests accordingly.

According to the current Physician's Order Sheet (POS) for 5/2016, R104 has diagnoses including Arthritis, Osteoporosis, Back Pain and Shoulder Pain. The POS lists an order dated 9/16/15 for Hydrocodone/Acetemin (narcotic analgesic) 5/325 milligrams, one to two tablets every four hours as needed for pain. R104's Controlled Substances Proof of Use form dated 9/29/15 lists E19 giving R104 two tablets of Hydrocodone on 10/2, 10/7, 10/8, 10/9 and 10/12/15. R104's Medication Administration Record for PRN (as needed) medications for 10/2015 does not list any Hydrocodone signed off or administered by E19.

R104's Urine Drug Screen dated 10/13/15 showed opiates as "non-detected."

According to the personnel file, E19 was terminated on 10/13/15 for "drug diversion." On 5/18/16 at 8:45am, E2 confirmed that E19 was terminated on that date. E2 also stated that information used for interpretation of the Urine Drug Screens came from the hospital testing laboratory. E2 confirmed the report information from the hospital that Hydrocodone stays in the body for 24 hours, but can be detected in the urine up to three to four days.

The summary report of this incident did not indicate that the State Survey Agency was sent the final report of the outcome of the investigation. The report also did not indicate if the IDFPR was notified of the substantiation of drug diversion.

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S9999	Continued From page 6 E2 and E1 stated on 5/19/16 at 10:00am that neither an initial nor a final report was sent to the State Agency and that they were unaware if a report was sent to IDFPR. (B)	S9999		